STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO 87 30524

OCT 20 1987 FOR STATE REGISTRAR

069147

1. DECEASED NAME (TYPE OR PRINT) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
Samuel	Vincent	Briscoe	10 06 87	1:55P M

3. SEX	4. RACE	5. DATE OF BIRTH Month Day Year	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	2 white	06 17 07	80 YRS		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. BALTIMORE CITY OR COUNTY OF DEATH
MARYLAND	USA	MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	Queen Anne's County MD

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Centreville	Meridian Nursing Center-Corsica Hills	machinist	milk processing

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Caroline	Ridgely	YES ☐ NO X	Route 1 Box 172 Ridgely, Md. 21660

14. FATHER'S NAME First Middle Last	15. MOTHER'S MAIDEN NAME First Middle Last
Samuel Briscoe	Bessie D. Morris

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		214-16-4201	Edith Briscoe	Ridgely, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH. Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Brain Tumor	3 mos
DUE TO, OR AS A CONSEQUENCE OF (b)	Ca. Diabetes Mellitus	years
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from Aug 12 19 87 to Oct 6 19 87 that (I) (we) last saw the deceased alive on Sept. 17 19 87 and that (to my) (to the) opinion death occurred on the date and hour and from the causes stated above. (I) (We) did (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
John R. Smith Jr	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐	10/ /87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
John R. Smith, Jr	Centreville Md 21617

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	10-9-87	Ridgely Cemetery	Ridgely CA MD

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
John E. Boulais	Greensboro, MD	OCT 13 1987	Julia Davidson-Landers

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified before

BP

DHMH 16 60M 7/84
(VRA 15, 4)

0695 87 OCT 23 87

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 30525

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 72 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 99. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE KNOWN OF DEATH / ESTIMATED	MONTH	DAY	YEAR	2b. HOUR
Joseph	L.	Brooks	X	9	24	19 87	8:30 M

3. SEX	4. RACE	5. DATE OF BIRTH MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS	DAYS	IF UNDER 24 HRS HOURS	MIN	2c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR
male	black	5	11	03	84 YRS.						9	24	19 87	9:00 M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. BALTIMORE CITY OR COUNTY OF DEATH
Virginia	USA	NEVER MARRIED X	Q.A. MD

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Chester	Home	retired	

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MD	Queen Anne	Chester	YES / NO X	P.O.Box 45 21619

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Joseph		Brooks	Mary		Brooks

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no		217-07-9755	Ida Richardson	P.O.Box 45 Chester, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	OSCUA	3 yrs +
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b)		
DUE TO, OR AS A CONSEQUENCE OF (c)		

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES / NO

21a. EXTERNAL CAUSE WAS UNDERLYING / CONTRIBUTING CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK / NOT WHILE AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE

22a. I certify that I took charge of the remains described above, held an Autopsy / Inspection X / Inquiry, and in my opinion death resulted from: Natural causes X / Accident / Suicide / Homicide / Undetermined manner.

ACTUAL SIGNATURE J.R. Smith Jr. M.D. TITLE (SPECIFY) Depuy MEDICAL EXAMINER

DATE SIGNED 9/25/87

EXAMINER'S NAME (TYPE OR PRINT) J.R. Smith Jr. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
burial	9/27/87	Chester	Chester	Q.A.	MD

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Eric L. Dashiell	P.O. Box 606 Easton, MD	OCT 20 1987	

BP

DHMH - 17
(VR A15 ME (5))
30M 7/73

5/

068392 OCT 14 87

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO 87 30520

1. DECEASED NAME (TYPE OR PRINT): First William Middle H. Last Carter

2a. DATE OF DEATH: Month 10 Day 6 Year 1987 — 2b. HOUR

3. SEX: Male

4. RACE: BLK

5. DATE OF BIRTH: Month 01 Day 16 Year 09

6. AGE (IN YEARS LAST BIRTHDAY): 78 YRS. — If under 1 year: Months / Days — If under 24 hours: Hours / Min.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MD

7b. CITIZEN OF WHAT COUNTRY?: USA

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Queen Anne MD

10. CITY OR TOWN OF DEATH: Stevensville

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 64 State Street

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Laborer

12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: MD

13b. COUNTY: Queen Anne

13c. CITY OR TOWN: Stevensville

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE: 64 State St. 21666

14. FATHER'S NAME: First James Middle S. Last Carter

15. MOTHER'S MAIDEN NAME: First Melvina Middle Last Hadrick

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 218-20-2536

17. INFORMANT: Bertha M. Carter ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		Approximate interval between onset and death
IMMEDIATE CAUSE (a)	Azotemia	3 mo
DUE TO, OR AS A CONSEQUENCE OF (b)	ASCVD	5 yrs
DUE TO, OR AS A CONSEQUENCE OF (c)	C.O.P.D	3 yrs +
	Diabetis mellitus	5 yrs

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I.

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH ☐ (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART II)

21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION: STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from July 1 1965 to Oct 6 1987 that (I) (we) last saw the deceased alive on Sept 22 1987 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: J.R. Smith DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 10-10-87

22d. PHYSICIAN'S NAME (TYPE OR PRINT): J.R. Smith M.D.

22e. ADDRESS: Centreville Md

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 10/12/87

23c. NAME OF CEMETERY OR CREMATORY: Bryan's Cemetery

23d. LOCATION: CITY OR TOWN Grasonville COUNTY QA STATE MD

24. FUNERAL DIRECTOR: NAME Grove Dashiell ADDRESS 31 E. Dover St. Easton MD

25a. DATE REC'D BY REGISTRAR: OCT 12 1987

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Landers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please see that page 2 should be filed with in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP_____

DHMH 16 60M 7 84
(VRA 15, 4)

068489 OCT 14 87

Item 6 Film 9632 10-13-87 For Funeral Home SB

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- STATE REGISTRAR

REG. NO. 30527

DECEASED NAME (TYPE OR PRINT): Marcus Whitman Dean

2a DATE OF DEATH KNOWN X ESTIMATED ☐: 10/ 1/ 87 — 2b HOUR: M

3 SEX: Male — 4 RACE: White — 5 DATE OF BIRTH: 09-10-73 — 6 AGE (IN YEARS LAST BIRTHDAY): 15 YRS. — IF UNDER 1 YR. MONTHS / DAYS — IF UNDER 24 HRS. HOURS / MIN.

2c DATE PRONOUNCED DEAD: 10/ 1/ 87 — 2d HOUR: 2:03 a M

7a BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland — 7b CITIZEN OF WHAT COUNTRY?: U.S.A. — 8 MARRIED ☐ NEVER MARRIED X WIDOWED ☐ DIVORCED ☐

9 BALTIMORE CITY OR COUNTY OF DEATH: Queen Anne's County MD

10 CITY OR TOWN OF DEATH: Stevensville — 11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 809 Kimberly Way 21666 — 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Student — 12b KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a STATE: Maryland — 13b COUNTY: QueenAnne's — 13c CITY OR TOWN: Stevensville — 13d INSIDE CITY LIMITS? YES X NO ☐ — 13e STREET ADDRESS: 803 Kimberly Way 21666

14 FATHER'S NAME: Frederick Anthony Dean — 15 MOTHER'S MAIDEN NAME: Linda Kay Archer

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No — (IF YES, GIVE WAR OR DATES):

16b SOCIAL SECURITY NO.: 217-92-2718

17 INFORMANT: Frederick A. Dean, 803 Kimberly Way, Stevensville, MD 21666

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Gunshot Wound of Head (rifle)

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I a.

19a DATE OF OPERATION:

19b CONDITION FOR WHICH OPERATION WAS PERFORMED?:

20 AUTOPSY? HEAD ONLY YES X NO ☐

21a EXTERNAL CAUSE WAS UNDERLYING X OR CONTRIBUTING ☐ CAUSE OF DEATH

21b TIME OF INJURY HOUR XX MONTH DAY YEAR: P.M. 9/ 30/ 87

21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2): self inflicted wound

21d INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK X

21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.): on street at

21f LOCATION STREET / CITY OR TOWN / COUNTY / STATE: 809 Kimberly Way, Stevensville, Queen Anne, Md

22a I certify that I took charge of the remains described above at HEAD ONLY Autopsy X Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☐ Accident ☐ Suicide X Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: [signature] TITLE (SPECIFY): Assistant MEDICAL EXAMINER — DATE SIGNED: 10/1/87

EXAMINER'S NAME (TYPE OR PRINT): Dennis F. Smyth, M.D. — ADDRESS: 111 Penn St., Balto., Md. 21201

23a BURIAL, CREMATION, REMOVAL (SPECIFY): Burial — 23b DATE: 10-03-87 — 23c NAME OF CEMETERY OR CREMATORY: Stevensville Cemetery — 23d LOCATION CITY OR TOWN / COUNTY / STATE: Stevensville Q.A. MD

24 FUNERAL DIRECTOR NAME / ADDRESS: Tom Helfenbein Funeral Home, Chester, MD 21619

25a DATE REC'D BY REGISTRAR: OCT 07 1987 — 25b REGISTRAR'S SIGNATURE: [signature]

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. (SEE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07-84 25M BP

DHMH - 17 (VR A15 ME (5))

070496 NOV 2-87

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO 87 030 28

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2 and 3 should be filed with the State Dept of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked on Item 18 shows any injury, or other traumatic event, the medical examiner must be notified [illegible]

1. DECEASED NAME (TYPE OR PRINT) FIRST: GEORGE	MIDDLE: OLIVER	LAST: DOWNES	2a. DATE OF DEATH MONTH DAY YEAR: OCT 23 1987	2b. HOUR: M	
3. SEX: MALE	4. RACE: NEGRO	5. DATE OF BIRTH MONTH DAY YEAR: MAR 3 1919	6. AGE (IN YEARS LAST BIRTHDAY): 68 YRS	IF UNDER 1 YEAR: MONTHS DAYS	IF UNDER 24 HRS: HOURS MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Rock Hall MD	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: QUEEN ANNE MD		
10. CITY OR TOWN OF DEATH: Sudlersville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): APT 4D DOGWOOD VILLAGE		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): LABORER	12b. KIND OF BUSINESS OR INDUSTRY: BLDG SUPPLY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MARYLAND	13b. COUNTY: QA	13c. CITY OR TOWN: SUDLERSVILLE	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS / ZIP CODE: APT 4 D DOGWOOD VILLAGE 21668	
14. FATHER'S NAME FIRST: IRVIN	MIDDLE	LAST: DOWNES	15. MOTHER'S MAIDEN NAME FIRST: CARRIE	MIDDLE	LAST: WILLIAMS
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO	(IF YES, GIVE WAR OR DATES): N/A	16b. SOCIAL SECURITY NO.: 218-16-9487	17. INFORMANT: DEBRA D WILSON	ADDRESS: MILLINGTON MD 21651 RT 1 BOX 325 C	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): cardiac arrest +

DUE TO, OR AS A CONSEQUENCE OF (b): congestive heart failure

DUE TO, OR AS A CONSEQUENCE OF (c): coronary artery disease

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART II OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. **I certify** that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: M MD	DEGREE: MD ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED: 10/28/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Michael Bienenfeld, M.D.	22e. ADDRESS: KENT & QUEEN ANNE'S HOSPITAL CHESTERTOWN, MD 21620	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL	23b. DATE: 10/31/87	23c. NAME OF CEMETERY OR CREMATORY: Chesterville Cem.	23d. LOCATION CITY OR TOWN: MILLINGTON COUNTY: KENT STATE: MD
24. FUNERAL DIRECTOR NAME / ADDRESS: Fellows F.H. Box 270 MILLINGTON MD 216	25a. DATE REC'D BY REGISTRAR: OCT 30 1987	25b. REGISTRAR'S SIGNATURE: Julia Pinkston-Lindsay	

BP_____

DHMH - 16 60M 7/84
(VRA 15. 4)

069280 OCT 21 87

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 87 30527

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 3 and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1. DECEASED NAME (TYPE OR PRINT) — FIRST: Authur; MIDDLE: ; LAST: Jones			7a. DATE OF DEATH MONTH DAY YEAR: 10-11-87	7b. HOUR: 9:35 P.M.
3. SEX: Male	4. RACE: Black	5. DATE OF BIRTH MONTH DAY YEAR: Mar. 6, 1919	6. AGE (IN YEARS LAST BIRTHDAY): 68 YRS	IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS.: HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Md.	7b. CITIZEN OF WHAT COUNTRY?: U.S.	8. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: ~~Dorchester~~ Queenstown Co.	MD
10. CITY OR TOWN OF DEATH: Centerville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Meridian Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Retired	12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Md.	13b. COUNTY: Dorchester	13c. CITY OR TOWN: Taylors Island	13d. INSIDE CITY LIMITS? YES ☐ NO ☐	13e. STREET ADDRESS / ZIP CODE: P.O. Box 61 Taylors Island, Md. 21669
14. FATHER'S NAME — FIRST: Samuel; MIDDLE: R.; LAST: Jones			15. MOTHER'S MAIDEN NAME — FIRST: Bertha; MIDDLE: ; LAST: Mundy	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 218-05-1594	17. INFORMANT: Dorothy Jones	ADDRESS: Taylors Island, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** Enter only one cause per line for (a), (b) and (c).

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): Gastric Carcinoma — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Gastrointestinal Hemorrhage

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) ☐	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART II)	
21d. INJURY OCCURRED (WHILE AT WORK ☐ NOT WHILE AT WORK ☐)	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION (STREET, CITY OR TOWN, COUNTY, STATE)	

22a. **I certify** that (I) (this hospital) attended the deceased from 10/1 19 87 to 10/11 19 87 that (I) (we) last saw the deceased alive on ____ 19 ____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.

22b. SIGNATURE: [signature]	DEGREE: ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED: 10/20/87
22d. PHYSICIAN'S NAME (TYPED OR PRINTED): Sprose	22e. ADDRESS: PO Box 210 Queenstown MD 21658	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 10-15-87	23c. NAME OF CEMETERY OR CREMATORY: Lane Cem.	23d. LOCATION (CITY OR TOWN, COUNTY, STATE): Taylors Island, Dor. Co. Md.
24. FUNERAL DIRECTOR (NAME): Stewart Funeral Home	(ADDRESS): Cambridge, Md.	25a. DATE REC'D BY REGISTRAR: OCT 20 1987	25b. REGISTRAR'S SIGNATURE: [signature]

BP____

DHMH 16 60M 7/84
(VRA 15.4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG NO 30536

0705 09 NOV -2 87

1. DECEASED NAME (TYPE OR PRINT): FIRST RICHARD; MIDDLE JAMES; LAST STEWART JR.

2a. DATE OF DEATH: KNOWN [X] ESTIMATED [ ] 10-28-87 (MONTH DAY YEAR) — 2b. HOUR

3. SEX: Male — 4. RACE: White — 5. DATE OF BIRTH: 9-14-1972 (MONTH DAY YEAR) — 6. AGE (IN YEARS LAST BIRTHDAY): 15 YRS — IF UNDER 1 YR: MONTHS, DAYS; IF UNDER 24 HRS: HOURS, MIN

7c. DATE PRONOUNCED DEAD: 10-28-87 — 7d. HOUR: 10:40

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Md. — 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. — 8. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: Queen Anne's County MD

10. CITY OR TOWN OF DEATH: Chester — 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Rt. 552 Dominion Road — 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Student — 12b. KIND OF BUSINESS OR INDUSTRY: -

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Md. — 13b. COUNTY: Queen Anne — 13c. CITY OR TOWN: Chester — 13d. INSIDE CITY LIMITS? YES [ ] NO [X] — 13e. STREET ADDRESS: Cox Neck Rd. Rt. 2 Box 51A 21619

14. FATHER'S NAME: FIRST Richard; MIDDLE James; LAST Stewart Sr.

15. MOTHER'S MAIDEN NAME: FIRST Lillian; MIDDLE; LAST Hudson

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): no — (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 213-86-4998

17. INFORMANT: Judy Hopkins (friend) — ADDRESS: 5518 Whitwood Rd. 21206

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cranio-cerebral trauma

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

19a. DATE OF OPERATION — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? — 20. AUTOPSY? YES [X] NO [ ]

21a. EXTERNAL CAUSE WAS UNDERLYING XX OR CONTRIBUTING [ ] CAUSE OF DEATH

21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR: 6:15P 10-28-87

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2): cyclist struck by an auto(s)hit and run

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.): hgwy.

21f. LOCATION: STREET Rt. 552; CITY OR TOWN Dominion Road; COUNTY Chester; STATE Maryland

22a. I certify that I took charge of the remains described above, held an Autopsy [X], Inspection [ ], Inquiry [ ] and in my opinion death resulted from: Natural causes [ ] Accident [X] Suicide [ ] Homicide [ ] Undetermined manner [ ]

ACTUAL SIGNATURE: Dennis F. Smyth M.D. — TITLE (SPECIFY): Assistant MEDICAL EXAMINER — DATE SIGNED: 10-29-87

EXAMINER'S NAME (TYPE OR PRINT): Dennis F. Smyth, M.d. — ADDRESS: 111 Penn Street

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL — 23b. DATE: 11/2/87 — 23c. NAME OF CEMETERY OR CREMATORY: Moreland Mem. Park — 23d. LOCATION CITY OR TOWN: Baltimore COUNTY: Md.

24. FUNERAL DIRECTOR NAME: SCHIMUNEK FUNERAL HOME, INC. — ADDRESS: 3331 Brehms Lane Balto. Md. 21213

25a. DATE REC'D BY REGISTRAR: OCT 30 1987 — 25b. REGISTRAR'S SIGNATURE: [signature]

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM, PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84 25M BP

DHMH - 17 (VR A15 ME (5))